

MANAGEMENT OF INFECTIOUS DISEASE IN THE CONTEXT OF MOLECULAR DIAGNOSTIC METHOD ON THE DETECTION

Rajkumar,

Research scholar, Department of Microbiology,
C.M.J. University, Jorabat, Meghalaya.

Dr. Narendra Kumar,

Research Supervisor, Department of Microbiology,
C.M.J. University, Jorabat, Meghalaya.

1.1 INTRODUCTION

Tuberculosis (TB) is a horrendous illness that has been known since old times. Robert Koch found the tuberculosis-causing bacillus, *Mycobacterium tuberculosis* (MTB), in 1882. He exhibited this by confining from perished tuberculosis patients and afterward tainting various creature models that capitulated to the sickness. In 1905, he was granted the Nobel Prize in physiology or medication for this revelation. Notwithstanding progressions in diagnostics, immunization, and treatment techniques, various obstructions to fast TB diagnostics and compelling treatment endure after over a long period. Today, tuberculosis rates eighth on the rundown of the main sources of death around the world. It is the second driving irresistible infection executioner, after the human immunodeficiency infection (HIV).

TB is one of the world's best three irresistible executioners, with around 9.4 million new cases each year, 1.7 million fatalities, and 4,500 passings for every day. The rise of exceptionally destructive strains and the constantly expanding number of multidrug-resistant and broadly drug-resistant types of tuberculosis have added to this sharp expansion in mortality. Drug resistance TB represents a critical hindrance to the administration of this infection. It at last outcomes in expanded dismalness, mortality, and the rise of a more noteworthy number of sickness-resistant strains. As per the World Wellbeing Association, tuberculosis is a worldwide pandemic. As indicated by a Walk 2010 WHO truth sheet on tuberculosis, 33% of the total populace (north of 2 billion) is by and by contaminated with the TB bacillus. As per this hypothesis, somebody on the planet is recently defiled with TB bacilli consistently, and one out of ten of these recently tainted people will turn out to be sick or infectious later in life. Tuberculosis (TB) is an infectious illness that is fundamentally brought about by the microbes *Mycobacterium tuberculosis* (MTB) and, less significantly, by other *Mycobacterium* species that contain the *Mycobacterium tuberculosis*

complex (MTBC), which incorporates *M. canettii*, *M. tuberculosis*, *M. africanum*, *M. microti*, *M. pinnipedii*, *M. Preceding* the last third of the twentieth hundred years, most of instances of dynamic pneumonic tuberculosis (PTB) were viewed as reparable on the off chance that the patient stuck to the recommended treatment. Any other way, patients could at last quit answering their treatment. The World Wellbeing Association (WHO) suggested a worldwide TB control technique named straightforwardly noticed treatment, short-course (Spots) in 1993 because of this situation. Spots is the most practical strategy for forestalling the spread of tuberculosis in networks with a high frequency, as per the World Wellbeing Association. This declaration is valid provided that the MTB strain is delicate to the first-line hostile to tuberculosis prescriptions (isoniazid, rifampin, ethambutol, and pyrazinamide). The TB epidemiological issue emerged when drug-safe *M. tuberculosis* (MTB) strains arose on the worldwide stage. Spots became incapable in a significant level of TB patients with DR-TB, especially when the causative specialists were impervious to rifampin and isoniazid (the best enemy of TB drugs). This sort of DR-MTB strains is known as MDR-MTB (multidrug-safe MTB). Because of this situation, the WHO encouraged all state run administrations to execute the Dabs in addition to methodology. The Dabs in addition to routine comprises of no less than two meds to which the separate is vulnerable, including one medication directed parenterally for something like a half year to patients with MDR-TB. The TB epidemiological circumstance has demolished throughout the long term. In 2006, the WHO proclaimed a crisis with respect to another type of DR-TB. Preceding quite a while back, this type of tuberculosis was known as broad medication safe TB strains (XDR-TB) and was thought of as basically untreatable with traditional drugs. XDR-TB is MDR-TB that is moreover impervious to something like three second-line drugs [6]. Regardless, in any event, for these outrageous instances of DR-TB, there is potential for a fix, as clever medications are at present being created. In this way, it is fundamental to distinguish the causative specialist of tuberculosis and to decide if MTB microbes are delicate to first-line against tubercular medications or safe; in the last option case, it is additionally important to characterize the medication opposition profile of every particular clinical MTB segregate.

Notwithstanding the logical advances — depicted underneath — to distinguish and portray MTB disengages, it stays a huge test, especially for non-industrial countries, to prepare and utilize qualified faculty and lay out satisfactory indicative research centers. Various countries have joined the endeavors of the WHO and different associations, for example, the Stop Tuberculosis Organization, to work on the distinguishing proof and treatment of instances of pneumonic tuberculosis. To contain and control TB, it is fundamental for increment the endeavors of all gatherings included, including researchers, clinical experts, legislatures, magnanimous associations, and the

overall population. The presence of XDR-TB is an uncontrolled risk that can possibly form into a pandemic with horrendous impacts.

Drug opposition in MTB detaches is basically obtained through unconstrained changes, especially single nucleotide polymorphisms (SNPs), in the roundabout chromosome, as per past exploration. For every enemy of tuberculosis drug, changes in at least one qualities have been depicted, and every transformation is related with shifting levels of medication obstruction. Transformation recurrence can likewise vary. For instance, 97% of instances of RIF obstruction are related with changes in the rpoB quality, prevalently in a 81 bp area of interest district (codon 507 to codon 533; Escherichia coli numbering framework, involved all through the text for RIF). The recurrence of transformations at codons 526-531 of rpoB is the most noteworthy and gives significant level RIF opposition. Protection from isoniazid (INH) is procured through changes in the katG, inhA and its advertiser, ahpC, ndh, and furA qualities, however basically in katG, inhA and its advertiser. Most of katG changes (50-90%) happen at codon 315 and give INH opposition at a significant level. Most ethambutol (EMB)- safe segregates (47-62%) contain changes at codon 306 of the embB locus. Likewise portrayed are transformations related with protection from second-line drugs. In streptomycin (STR)- safe MTB secludes, codons 43 and 88 of the rpsL quality and codon 514 of the rrs quality contain the most successive changes. Fluoroquinolone (FQ) obstruction is brought about by transformations in the gyrA and gyrB qualities. Sixty to over two thirds of quinolone-safe MTB segregates contain changes in the quinolone opposition deciding area of gyrA, with the most elevated recurrence at codon 94, trailed by codons 90, 91, and 88 (Laurenzo and Mousa, 2011). Seldom do transformations happen in the gyrB quality. Protection from second-line injectable prescriptions, for example, amikacin (AMK), kanamycin (KAN), and capreomycin (CAP), is fundamentally brought about by changes in the rrs quality. The rrs A1401G change represents around 70-80% of CAP obstruction and 60% of KAN opposition. Albeit the components of medication opposition are hazy in 10-40% of DR-MTB secludes without transformations, the location of realized changes empowers a high extent of DR-MTB to be distinguished.

To give reasonable, exact, simple, and quick symptomatic tests for DR-TB identification, various nucleic corrosive based measures that distinguish changes connected with against TB drug opposition have been created as of late. In this survey, we will examine the benefits and disservices of the monetarily accessible sub-atomic tests for DR-TB identification.

1.2 REVIEW OF LITERATURE

Internationally, in excess of 7×10^6 new instances of tuberculosis (TB) are brought about by Mycobacterium tuberculosis (MTB), and 1×10^6 individuals kick the bucket yearly. To invert this pattern, the World Wellbeing Association (WHO) has carried out a three-pronged procedure, which incorporates the improvement of powerful indicative and treatment instruments.³ The Unified Countries orders mycobacterium tuberculosis (MTB) as an unsafe organic substance B, requiring a counteraction level (CL) of 3 while working with MTB-positive examples. CL3 research facilities are exorbitant to build and keep up with. As a result, most of countries have local or public TB culture benefits that are incorporated. This demonstrates that smear microscopy is the most available symptomatic strategy in distant clinical offices.

WHO has endorsement to carry out fast sub-atomic tests, like Master MTB/RIF, in Level 4 wellbeing offices, which are basically situated in Region Level 4, 5, and Level 4 locale. A few regions are fundamentally bigger and less open than others. While worthwhile, XPT MTB/RIF capabilities by recognizing MTB DNA. DNA is a steady particle that endures long after cell passing; consequently, it's anything but a reasonable norm for estimating feasible cells, which are fundamental for deciding treatment reaction. ^{5,6} RNA-based examines give the choice of not estimating practical cells definitively. ^{7,8, 9,10,11,, 12,12,13}. There are three types of RNA with contrasting dependable qualities: ribosomal RNA (rRNA), move RNA (tRNA), and courier RNA (mRNA). Courier RNA is generally firmly connected with cell movement and practicality because of its relationship with quality articulation. ¹⁴. Critically, the shortfall of quality articulation isn't identical to cell demise since microorganisms, for example, Mtb are available in idle however suitable states ^{15,16}. In this way, stable RNA species, for example, rRNA are unrivaled markers of both dynamic and idle conditions of feasible cells.

Utilizing Escherichia coli, Sheridan exhibited that the count of 16S rRNA expanded relatively with bacterial expansion as estimated by settlement shaping units (CFU). At the point when E. coli microscopic organisms were presented to anti-toxins, there was a simultaneous decrease in CFU counts and 16S rRNA. The lessening in RNA after cell mortality showed that it very well may be utilized as a marker for cell suitability, as shown by studies ^{13,17}. TB Sub-atomic Microorganisms Weight Examine (TB-MBLA) to target M tuberculosis 16S rRNA to quantify feasible TB bacillary burden as a marker of treatment reaction for patients on enemy of TB treatment depends on this hypothesis. ^{11, 18, 19}, We have additionally evolved and adjusted TB-MBLA to incorporate a cell extraction control that distinguishes lysis of M. tuberculosis bacilli and is powerful in 20 particular natural settings. To guarantee specialist wellbeing, the primary phase of RNA detachment from MTB should be acted in a CL3 lab until the MTB cells are totally lysed. Likewise, tests for review mass examination will be safeguarded at

80 ° C in guanidine thiocyanate, a level 4 poison, until examination. To this end, we have utilized intensity to deliver TB and smear tests innocuous for microscopy-level TB-MBLA testing in research centers.

Heat has been used in research center and clinical applications for a really long time around 21,22. In any case, certain microorganisms, like Mtb, are trying to kill, and low intensity openness is deficient to obliterate all cells 23, 24. In one review, warming TB societies at 80 ° C for 20 minutes annihilated all Mtb bacilli without obliterating the DNA expected for PCR²⁵. Thus, various research facility DNA extraction techniques presently arrive at temperatures of 95 ° C. We used a similar standard to exhibit that bubbling TB tests at 80 ° C, 85 ° C, or 95 ° C delivered Mtb latent while safeguarding adequate RNA for TB-MBLA. Societies or sputum that are idle can be put away in safely fixed compartments at room temperature or in the cooler for seven days without the amount of quantitative rRNA lessening.

TB-MBLA is versatile and has been applied to different example types, including sputum, lung tissue, and cerebrospinal liquid. It has not yet been applied to bronchial alveolar liquid, blood, or different types of tests. Involving drool as an example, multisite assessment in Africa (unpublished information) and past distributions 18, 26 demonstrate that MBLA powerlessness is predictable with Mycobacterium development pointer tube (MGIT) fluid culture. TB-MBLA, then again, gives brings about hours instead of days or weeks with culture, is unaffected by non-TB microorganisms, and gives a quantitative proportion of illness seriousness. The WHO has as of late proposed TB-MBLA as a choice to spread microscopy and culture for checking TB treatment 2. Tuberculosis (TB) has been predominant among people since antiquated times. Proof of tuberculosis among Neolithic man has been gathered from bones recuperated in different pieces of the globe. Proof of tuberculosis in the spine was found in preserved cadavers recuperated from old Egyptian etchings. These show that TB impacted the human species as soon as 5000 BCE.

In India, depictions of tuberculosis showed up as soon as 300 B.C. Susruta, an eminent Indian specialist, expressed that the sickness was trying to treat. Hippocrates (460-375 BC) was of the assessment that treating tuberculosis was an exercise in futility and that TB patients were a weight on society. Galen (130-200 Promotion) portrayed the sickness as hopeless and infectious .

In 1895, Wilhelm Rontgen was quick to reveal the presentation of a procedure using radiation to follow the movement of sickness in patients. Guerin and Calmette, two French bacteriologists, found the Bacillus Calmette Guerin (BCG) immunization to decrease the harmfulness of cow-like tuberculosis utilizing a unique culture medium, among other critical advances in the treatment of sickness.

1.3 OBJECTIVES:

The study's primary purposes and objectives are:

1. To evaluate the performance of the Allele-Specific Depletory PCR (ASD-PCR) assay for the detection of drug-resistant Mycobacterium tuberculosis.
2. Comparing ASD-PCR to conventional methodologies for detecting drug resistance in Mycobacterium tuberculosis strain.

1.4 RESEARCH METHODOLOGY

The protocol

1. Sample Culture of Preparation

The exponential phase Bacillus Castellate-Guérin (BCG) culture is harvested in 1 ml aliquots in 15 m plastic centrifuge tubes on a spotless bench or class 1 cabin. Seal the tubing securely.

The processing of a 5 mL sample requires five 15 mL centrifuge containers. When operating with any TB culture, a biosafety cabinet is required.

Patient sputum specimen

Working in a well-ventilated area and while wearing a face mask, open the sample cup with care, pour a 1 mL aliquot into 15-meter plastic centrifuge tubes, and seal the tubes securely.

To pipette spit, it is recommended to use a tip with a wide aperture. Using scissors, remove 1 mL from the right side of the mouth to produce a wider opening.

2. deactivation by heat

Before preparing the sample, heat the water bath to 95 °C.

Note: 95 °C enhances the likelihood of reducing RNase activity, thereby protecting more RNA for TB-MBLA processing.

Place sample containers on a rack submerged in the water bath. Ensure that water covers three-quarters of each sample vial.

Before beginning RNA extraction, boil at 95 ° C for 20 minutes, then transfer the containers to a bench to cool to room temperature.

Verification of complete heat inactivation of *M. tuberculosis* bacilli and BCG was accomplished by incubating heat-inactivated samples and controls at 37 ° C for 42 days in order to observe growth. The optical density at 600 nm (OD 600) was measured initially and then weekly for 42 days during the incubation period.

3. Extraction of RNA

Note: The RNA extraction procedure described in this article applies to the RNA extraction kit specified in the table of contents. Various manufacturers may utilize additional suitable RNA extraction packages.

Addition of Extraction Control (EC)

Transfer 1 mL aliquots of samples that have been heat inactivated to 1.5 mL containers. Place 100 µL of EC in each sample, close the tube, and invert it three times.

Note: EC is included in the TB-MBLA Vital Bacteria Kit (Contents). Cell deposits

At room temperature, centrifuge the vials at 20,000 x g for 10 minutes using a benchtop microcentrifuge. Using the supernatant, pipette 50 µL of detritus.

Suspend the sediment in 950 µL of lysate buffer by pipetting up and down, then transfer the entire suspension to the lysing matrix tube included in the RNA extraction kit (table of contents). Ensure that the tubes close securely and label both the cap and the tube's side.

Move the tubes from step 3.2.2 to step 3.2.3 for cell lysis. Equalize the samples for 40 seconds at 6,000 revolutions per minute.

RNA and DNA purification

The lysate from step 3.3 is centrifuged at 12,000 x g for 5 minutes at ambient temperature. Add 300 µL of chloroform to each clean 1 mL vial.

Using a 1 mL tip, remove the supernatant without contacting the lysing matrix.

Transfer preferably to tubes containing chloroform and vortex for 5 seconds. Allow the tube to settle for at least five minutes, or until the three phases (top, middle, and bottom) are visible.

5 minutes of centrifugation at 12,000 x grams at ambient temperature. Transfer the contents of the upper stage with care into new 1.5 mL containers.

Add 500 L of ice-cold 100% ethanol to the tubes created in step 3.4.5, close the tubes, and mix slowly by inverting the tubes three times. Incubate the tubes at 80 ° C for 15 minutes or 20 ° C for 30 0 0 0 and continue extraction, or incubate at 20 ° C overnight and continue extraction the following day.

Adjust the microcentrifuge to 4 degrees Celsius and allow it to settle to at least 12 degrees Celsius before centrifuging. Load the containers into the microcentrifuge and spin for 20 minutes at 13,000 x gram. Replace the preceptor with 70% ice-cold ethanol and centrifuge for an additional 10 minutes at 13,000 x g.

Note: 70% ethanol must be produced with nuclease-free molecular-grade water.

Throw away all precipitates from step 3.4.7 and place the tubes in a 50 ° C incubator. Incubate for twenty minutes to dry the RNA/DNA palette. Keep the passages partially open to allow ethanol to evaporate.

Pour 100 m of free water into the dried palette and incubate for 5 minutes at room temperature. For three seconds, create a vortex to blend the material.

Research Groups

The project research groups included 181 TB-positive individuals, 19 TB-negative individuals confirmed by chest x-ray, and 42 individuals with extrapulmonary tuberculosis confirmed by culture positivity/histological evidence. All participants in the study were informed of the project's goals and objectives, methodology, and anticipated outcomes, as well as their rights regarding the use of their samples.

Sputum Negative Pulmonary Tuberculosis:

There were 19 confirmed sputum-negative individuals in this cohort, as determined by chest x-ray.

Sample Size:

The sample size was calculated using the equation

$$n = \frac{t^2 \times p(1-p)}{m^2}$$

Description:

n = required sample size

p = Percent Prevalence of the disease

t = confidence level at 95% (standard value of 1.96)

m = margin of error at 5% (standard value of 0.05)

Revised National Tuberculosis Control Program (RNTCP) Annual Status Report, TB

India 2013 statistics were used to calculate percent prevalence (104).

Total Indian Population = 1.2 Billion

Total cases of Tuberculosis = 3.1 Million

Therefore, the Percent Prevalence of the disease (p) =

All new and preexisting cases during a time period $\times 100 = 3.8416$

The population of India during the same time period

Therefore, the calculated sample size was 294. The proposal indicates that a minimum of 250 samples will be collected for the investigation. The proportion of smear-positive, smear-negative, and extrapulmonary tuberculosis (EPTB) cases was calculated as a fraction of total incidence according to Revised National Tuberculosis Control Program TB India 2013 statistics available at <http://www.tbfacts.org/tb-india.html>.

Exclusionary Standards

People under the age of 18 and expectant women were excluded from the study.

Collection and Processing of Samples

Ziehl Neelsen (ZN) Discoloration

a. Mycobacteria are acid-resistant owing to the presence of mycolic acid in their cell walls. This mycolic acid bonds with fuchsin, a red-colored primary stain. It is rinsed in concentrated acid. Even after intensive decolorization, Acid Fast Bacilli does not release primary stain. Counterstain (Methylene blue) creates a background contrast.

b. Size: The stain was prepared 2 to 3 centimeters in length by 1 to 2 centimeters in width or 3 X 2 centimeters (100 to 150 fields to be counted in one length) in the center of the slide.

c. Uniformity: A firm smear was applied perpendicular to the slide (Move in tiny concentric circles or coil-like patterns).

CONCLUSION

WHO at present suggests a course of therapy comprising of a two-month concentrated period of a mix of four anti-toxins: INH, RIF, EMB, and PZA. During this stage, the bacilli are killed moderately quickly, the patient becomes noninfectious, and side effects commonly vanish. The escalated stage is trailed by the purported continuation stage, a more extended enduring period of sanitization. It endures four to a half year and comprises of day to day or three-times-week by week organization of two of the first-line meds utilized in the past stage, fundamentally RIF and INH33. Irresistible patients are ordinarily separated in emergency clinics for quite a long time. The treatment of tuberculosis requires long haul, nonstop organization of numerous meds.

This concentrate really settled two new tests: the Circle Interceded Isothermal Examine (Light) for tuberculosis identification and the Allele-Explicit Depletory PCR (ASD-PCR) measure for identifying drug opposition in *M. tuberculosis*. The two tests were then contrasted with ordinary analytic methods. Utilizing phenotypic and genotypic techniques like Ziehl-Neelsen (ZN) staining, culture, Polymerase Chain Response (PCR), and financially accessible packs, for example, Line Test Examine (LPA), aspiratory and extrapulmonary tests were investigated at first. 181 (90.05%) of 200 all out PTB tests remembered for the investigation were spread positive, 179 (89.05%) were culture positive and LPA positive, and 182 (91%) were PCR positive. 22 (52.38%) of the 42 EPTB tests remembered for the examination were spread positive, 19 (45.23%) were culture positive, 18 (42.85%) were PCR positive, and 22 (52.38%) were LPA positive.

Of the three strategies for Nucleic corrosive extraction, specifically Qiagen, Himedia, and the in-house strategy, Qiagen was the most favored on the grounds that it gave the most elevated DNA yield without forfeiting uprightness. The extraction required 6 hours and cost Rs.200. That's what the current review exhibits, albeit economically accessible disengagement units are impressively more easy to understand, the suggested lysis time can be changed, normalized, and advanced to diminish the general time required to circle back of the measure without impacting its result.

We planned an in-house Light measure for the identification of *Mycobacterium tuberculosis* (MTB) utilizing the *gyrB* quality and 16S ribosomal DNA (rDNA) as the objective successions. The ideal outcomes were gotten when the blend was hatched in a dry arrangement at 67°C for 45 minutes. The responsiveness of the MTBLAMP preliminary set was assessed by sequentially weakening DNA and identifying 100 fg overlap weakened *M. tuberculosis* H37Rv items. Just *M. tuberculosis* showed enhancement, while no enhancement was seen in different strains. These discoveries demonstrate that the preliminaries utilized in this examination are profoundly unambiguous for distinguishing *M. tuberculosis*.

In this examination, Light showed high responsiveness and particularity similar to L.J culture and Z.N staining. On account of pneumonic tuberculosis tests, Light showed a responsiveness of 90.05 percent and an explicitness of 57.89 percent, in contrast with Z.N staining. Contrasted with L.J culture and fluid culture strategy, Light exhibited test responsiveness of 89.94% and explicitness of 52.38%. In contrast with business NAATs, for example, LPA and the Ampligen reagent, its responsiveness and explicitness were 89.94% and 100 percent, separately, and 52.38 and 96.66%, separately. Contrasted with in-house regular PCR examines, the responsiveness and explicitness of the Light were viewed as 90.10 percent and 61.11 percent, separately, demonstrating that a normalized Light might proceed as well as or better than PCR-based procedures.

M. tuberculosis weakness to rifampicin and isoniazid in view of a hereditary change in the RRDR of rpB and katG quality is accessible in 8 hours or less. This length depends on the time expected for DNA extraction from clinical examples, PCR, and enhancement. Beside time, the reasonableness of the demonstrative test is a significant variable, especially in settings with restricted assets. ASD-PCR costs 600 rupees for each example and is promptly performed with a fundamental warm cyler.

REFERENCES

1. Organization WH. Global tuberculosis report 2017. Geneva: World Health Organization;2017:66.
2. Organization WH. Global tuberculosis report 2013: World Health Organization;2013.
3. Chopra P, Meena L, Singh Y. New drug targets for Mycobacterium tuberculosis. Indian Journal of Medical Research. 2003;117:1-9.
4. Mehra R, Dhingra V, Nish A, Vashist R. Study of relapse and failure cases of CAT I retreated with CAT II under RNTCP—an eleven year follow up. Indian J Tuberc.2008;55:188-91.
5. Marais BJ, Pai M. Recent advances in the diagnosis of childhood tuberculosis. Archives of disease in childhood. 2007;92(5):446-52.
6. V. Joshi Suvarna STS, P. Vaidya Shashikant and S. Chowdhary Abhay. Comparison of Mycobacterium tuberculosis DNA Extraction Methods Journal of Pure and Applied Microbiology. Jun 2015;9(2):1129-36.
7. Morgan M, Kalantri S, Flores L, Pai M. A commercial line probe assay for the rapid detection of rifampicin resistance in Mycobacterium tuberculosis: a systematic review and meta-analysis. BMC Infect Dis. 2005;5:62.
8. Parashar D, Chauhan D, Sharma V, Katoch V. Applications of real-time PCR technology to mycobacterial research. Indian Journal of Medical Research.2006;124(4):385.
9. Dubiley S, Mayorova A, Ignatova A, Kirillov E, Stepanshina V, Kolesnikov A, et al. New PCR-based assay for detection of common mutations associated with rifampin and isoniazid resistance in Mycobacterium tuberculosis. Clinical chemistry.2005;51(2):447-50.
10. World Health Organization. Global Tuberculosis Control 2011: Epidemiology, Strategy, Financing. Geneva, Switzerland: WHO, 2011.

11. World Health Organization Regional Office for Europe, Copenhagen, Denmark 2012. The European health report 2012: charting the way to well-being. Geneva, Switzerland: WHO, 2012.
12. WHO. WHO policy statement: molecular line probe assays for rapid screening of patients at risk of multidrug-resistant tuberculosis. Geneva, Switzerland: WHO, 2008.